



Department of Veterans Affairs

Bay Pines VA Medical Center

Occupational Health Employee Questionnaire

Name: _____ SSN #: _____

Service: _____

Contact Information:

Home #: _____

Work #: _____

Pager #: _____

Do you have any allergies? ☐ Yes ☐ No List: _____

Have you ever had an allergic reaction to latex devices/products? ☐ Yes ☐ No

Have you ever had the Measles or the Measles Vaccine? ☐ Yes ☐ No

Have you ever had Chickenpox? ☐ Yes ☐ No

If not, would you be interested in receiving the Varicella (Chickenpox) vaccine? ☐ Yes ☐ No

When was your last Tetanus Vaccine? _____

Have you had the Hepatitis B Vaccine Series?

If Yes, What Dates:

Vaccine #1: _____

Vaccine #2: _____

Vaccine #3: _____

Did you have blood work complete to test for the Hepatitis B Antibody following the vaccine series?

☐ Yes ☐ No

Were you told you had positive antibodies for Hepatitis B following the vaccine series?

☐ Yes ☐ No

Were you ever told you had positive antibodies protecting you against Hepatitis B **WITHOUT** taking the vaccine?

☐ Yes ☐ No

Employee's Signature

Date